N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Facility Services 2718 Mail Service Center Mental Health Licensure and Certification Section Raleigh, North Carolina 27699-2718

LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

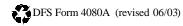
1. TYPE OF LICENSURE APPLICATION:	
Renewal ☐ Change of Facility Name ☐	*Change <u>of</u> Capacity
Change of Licensee/Ownership *Change of	Location (see application instruction sheet)
Other (specify):	License number: IVIHL
2. FACILITY NAME:	
(Name which the facility is advertised or presented to t	he public or the exact name on your current license)
2 F4 OU ITV OITE 4 DDDEGO (NO D 2 DOVEO) ('/	
3. FACILITY SITE ADDRESS: (NO P.O. BOXES) (if o	·
Street: Zip Code	
Facility Telephone Number ()	Fax Number ()
FACILITY CORRESPONDENCE MAILING ADDRE	:qq.
Address to:	
Street:	
City Zip Code	County
Email address:	
4. NAME OF FACILITY DIRECTOR:	
5. NAME OF CONTACT PERSON:	
Title:	
Telephone Number: ()	Fax Number:()
6. AUTHENTICATING SIGNATURE: This undersigned	d representing the governing authority submits
information for the above named facility and certifies the	
10A NCAC 27G.	is accordance of the fine financial in accordance with
Name	T:41
Name:	Title:
Signature:	Date:
When renewing a license, submit only the completed a	
Raleigh office at (919) 855-3795 FAX: (919) 715-8078	o the Mental Health Licensure and Certification Section OR Asheville office at (828) 232-5084 fax: (828) 232-
2433 *instituted Oct. 2003 G.S. 122G-23(h)	OTT / OHE VIIIE OFFICE AT (020) 202 0004 Tax. (020) 202
ALL ADDI 10 ATIONO MILOT DE MAII ED AND MILOT	THATE AN ADJOINAL CLANATURE
ALL APPLICATIONS MUST BE MAILED AND MUST	HAVE AN ORIGINAL SIGNATURE.
OFFICIAL USE ONLY:	
Licensura Cetagories	
Licensure Categories:Licensure Recommendation:	
Remarks:	
DFS Consultant:	



If change of ownership/licensee: (if no changes skip #7)

7.	SIGNATURE(S) OF	OLD	LICENSEE/A	PPLICAN1	Γ:
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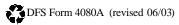
(Full legal name of individual,	partnership, corporation or other legal entity with ownership, liability, and governing authority)	
	NATURE(S) OF NEW LICENSEE: This undersigned, representing the governing ation for the above named facility and certifies the accuracy of this information in AC 27G.	
Name:	Title:	
Signature:	Date:	
Full legal name of individual business. Owner/Licen interest in the mental he business and will be rec	FOWNERSHIP/LICENSEE: ual, partnership, corporation or other legal entity which owns the mental health faci see means any person/business entity who has legal or equitable title to or a majori alth facility. This entity is responsible for financial and contractual obligations of the orded as the licensee on the license.	ity
Address.		
Business Phone # of Ap	olicant/Licensee: () Fax ()	
We ask that you volunta	per/Federal Tax ID number of Owner/Licensee:	this
(b) Legal entity is:	For Profit Not for Profit	
_	Proprietorship Corporation Partnership Government Unit Limited Liability Company Limited Liability Partnership	
(d) If the "licensee" is a Executive Officer or Ger	corporation or partnership list the name and other requested information of the eral Partner.	
Name:	Social Security Number:	
	<u> </u>	
Telephone Number: (_) Fax Number: ()	



Percentage interest in this facility: _____



YES NO	corporation, etc.) own the building no	iii wiildii services are ollereu!			
If "NO", give the name, address, phone	number of building owner:				
/					
(f) If NO individual holds an interest of 5% or more please indicate so by signing the statement below.					
There are no owners, partners, affilia entity applying for or renewing a lice		nterest of 5% or more of the			
Signature	Title	Date			
(g) List the names and other requested affiliates or shareholders holding an innecessary. Name:	nterest of 5% or more of the applican	nt entity. Attach additional pages			
Address:	•				
Telephone Number: ()					
Percentage interest in this facility:					
Name:	·				
Address: Telephone Number: () Percentage interest in this facility:	Fax Number: ()				
Name:	Social Security Number:				
Address:					
Telephone Number: ()	Fax Number: ()				
Percentage interest in this facility:					
Name:	Social Security Number:				
Address:					
Telephone Number: ()	Fax Number: ()				
Percentage interest in this facility:					





9. EXTENSIONS IN OWNERSHIP:

North Carolina General Statute also requires information about "affiliates" of the applicant entity. "Affiliate" means any individual, partnership, or corporation which controls a mental health facility and is also directly or indirectly controlled by the applicant entity; or any individual, partnership, or corporation which controls a mental health facility and also directly or indirectly controls the applicant entity.

(a) is the applicant entity controlled by any other organization that operates licensed mental health facility
Yes No
(b) Does the applicant entity control any other organizations that control any other licensed mental health
facilities? Yes No
(c) If the answer to (a) or (b) above is "Yes" list the name of the other organization(s) and provide the
requested information on the individuals who control 5% or more of that organization.*
Organization Name: Federal Tax ID Number:
Address:
Telephone Number: () Fax Number: ()
*Attach additional pages if necessary.
10. MANAGEMENT COMPANY Is this facility being managed by the licenses? Vec. No.
Is this facility being managed by the licensee?YesNo
If answered no above, give the following information about the management company:
Name:
Address:
Telephone Number: () Fax Number: ()
11. AREA AUTHORITY
Does this facility have a contract with one or more area mental health, development disability and
substance abuse authority?YesNo
If so, please list the name(s) of area authority or authorities:
12. ACCREDITATION : If the facility has been accredited by any nationally accrediting agency, give the nam of the agency, the date the site was last inspected by the agency, and the categories for which accreditation was granted:



13. SERVICE CATEGORIES:

Services subject to licensure under G.S. 122C are shown in the table below and **are found in the <u>Rules For Mental</u>** <u>Health, Developmental Disabilities and Substance Abuse Facilities and Services</u> book. All applicants must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank. **(www.dhhs.state.nc.us/mhddsas/forms/)**

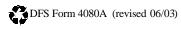
f change of service category	: Changing to:	Is now:	Adding:	
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Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		y Age
	Electise	0-17	18 & up	Total Beds
.1100 Partial hospitalizations for individuals who are acutely mentally ill.				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness (Max. of 12 clients)				
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances				
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness (Max. of 12 clients in each unit)				
		1	1	
.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON required)				
.2200 Before/after school and summer developmental day services for children with or at risk for developmental				
delays, developmental disabilities, or atypical development				
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities				
.2400 Developmental day services for children with or at risk for developmental delays, developmental disabilities or atypical development. (can be licensed thru DCD)				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License		Beds Assigned by Age	
		0-17	18 & up	Total Beds
.3100 non-hospital medical detoxification for individuals				
who are substance abusers (CON required)				
.3200 Social setting detoxification for substance abuse				
(CON required)				
.3300 Outpatient detoxification for substance abuse				
.3400 Residential treatment/rehabilitation for individuals				
with substance abuse disorders (CON required)				
.3500 Outpatient facilities for individuals with substance				
abuse disorders (Max. of 20 participants)				
.3600 Outpatient narcotic addiction treatment				
.3700 Day treatment facilities for individuals with				
substance abuse disorders				
.4100 Therapeutic homes for individuals with substance				
abuse disorders and their children (Min. 3 clients)				
.4300 A supervised therapeutic community for				
individuals with substance abuse disorder				



Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
5000 Facility based crisis service for individuals of all				
disability groups				<u> </u>
5100 Community respite services for individuals of all				
lisability groups				
5200 Residential therapeutic (habilitative) camps for				
children and adolescents of all disability groups				
5400 Day activity for individuals of all disability groups				
5500 Sheltered workshops for individuals of all disability				
roups				
Rule 10A NCAC 27G Licensure Rules For Mental	Check]	Beds Assigned by	Age
lealth Facilities	Service of			8.
	License			
7,000]	0-17	18 & up	Total Beds
. 5600 Supervised living for individuals of all disal	oility groups	(CON required	tor ICF/MR t	acility)
600A Group homes for adults whose primary diagnosis				
· · · · · · · · · · · · · · · · · · ·				
s mental illness (Max. of 6 clients)				
600 B Group homes for minors whose primary diagnosis				
mental retardation or other developmental disabilities				
Max. of 6 clients)				
6600C Group homes for adults whose primary diagnosis				
mental retardation or other developmental disabilities				
Max. of 6 clients)				
600 D Group homes for minors with substance abuse				
oblems				
6600E Half-way houses for adults with substance abuse				
roblems				
6600 F Alternative family living - providing services in				
vn private residence (Max. of 3 clients)				
4. NUMBER OF CLIENTS: (skip #13 & 14 if fumber of clients for which the facility is going to the control of the	to be license (number th atory, 1-3	d to service at are able to		vithout assis
Are any of these non-ambulatory? Yes	No 🗌			
16. SIGNATURE OF PERSON RESPONSIBL Signature		FURMATI	ON ON TH Date:	IS APPLIC
Signature			Date	





Please complete this page if you are submitting this application for a physical change of location of facility.

PHYSICAL PLANT:

- Provide directions or map from the nearest major highway, street or intersection.
- Provide documentation that the proposed facility is approved through the local Zoning Department for the proposed use.
- Submit pictures and floor plane with dimensions of home

1. Authorities Having Jurisdiction		
Local Building Official:		
Department Name:		·
Address		
	County	
Telephone()		
Local Fire Marshal:		
Department Name		
Address		
City	County	
Telephone()		
Local Sanitation:		
Department Name		
Address		
City	_ County	
Telephone()		
2. Building Information:		
Has the building housed a licensed fac	cility previously? Yes \(\square\) No \(\square\)	
If Yes: Type of licensed facility		
Previous License #	Dates of Licensure From	To
Does this building(s) contain facilities	licensed for a different use other than the	one an initial license is being
sought for? Yes No No		
If Yes, please clarify		
Is the building a site constructed home	e or a *manufactured/mobile home?	
(* If it is a manufactured/mobile home-contactured/mobile home-contactured/mob	et the DFS Construction Section for licensure limita	itions on this type of structure.)



If it is a manufactured/mobile home, was it built after 1976? Yes \(\Boxed{\scales}\) No \(\Boxed{\scales}\)